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State/Territory Name: IA

State Plan Amendment (SPA) #: 21-0014

This file contains the following documents in the order listed:

- 1) Approval Letter
- 2) CMS 179 Form/Summary Form (with 179-like data)
- 3) Approved SPA Pages



Financial Management Group

December 15, 2021

Ms. Elizabeth Matney, Medicaid Director
Iowa Medicaid Enterprise
1305 E. Walnut Street
Des Moines, IA 50319

RE: IA 21-0014

Dear Ms. Matney:

We have reviewed the proposed amendment to Attachments 4.19-D of your Medicaid State plan submitted under transmittal number (TN) 21-0014. This SPA rebases nursing facility rates effective July 1, 2021

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30), and 1903(a) of the Social Security Act and the implementing Federal regulations at 42 CFR 447 Subpart C.

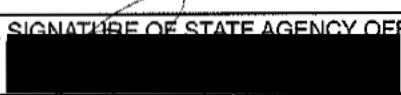
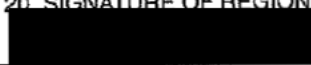
This is to inform you that Medicaid State plan amendment IA 21-0014 is approved effective July, 1, 2021. The CMS-179 and the amended plan page(s) are attached.

If you have any additional questions or need further assistance, please contact Fred Sebree at Fredrick.sebree@cms.hhs.gov.

Sincerely,

A solid black rectangular box used to redact the signature of the sender.

Rory Howe
Director

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES		1. TRANSMITTAL NUMBER <u>2 1 0 1 4</u>	2. STATE IOWA
		3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR CENTERS FOR MEDICARE & MEDICAID SERVICES DEPARTMENT OF HEALTH AND HUMAN SERVICES		4. PROPOSED EFFECTIVE DATE July 1, 2021	
5. TYPE OF PLAN MATERIAL (Check One)			
<input type="checkbox"/> NEW STATE PLAN <input type="checkbox"/> AMENDMENT TO BE CONSIDERED AS NEW PLAN <input checked="" type="checkbox"/> AMENDMENT			
COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate transmittal for each amendment)			
6. FEDERAL STATUTE/REGULATION CITATION		7. FEDERAL BUDGET IMPACT	
		a. FFY <u>2021</u> \$ <u>15,785</u>	
		b. FFY <u>2022</u> \$ <u>62,380</u>	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT Attachment 4.19-D, Pages 2, 2a, 5a, 5b		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable) Attachment 4.19-D, Pages 2, 2a, 5a, 5b	
10. SUBJECT OF AMENDMENT			
The Department of Human Services is implementing additional total state funds for nursing facility rates effective July 1, 2021, as authorized in HF 891. The amount above is the estimated fee-for-service portion.			
11. GOVERNOR'S REVIEW (Check One)			
<input checked="" type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input type="checkbox"/> OTHER, AS SPECIFIED <input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL			
12. SIGNATURE OF STATE AGENCY OFFICIAL 		16. RETURN TO	
13. TYPED NAME Elizabeth Matney		ELIZABETH MATNEY MEDICAID DIRECTOR DEPARTMENT OF HUMAN SERVICES 1305 EAST WALNUT 5TH FLOOR DES MOINES IA 50319-0114	
14. TITLE MEDICAID DIRECTOR			
15. DATE SUBMITTED September 22, 2021			
FOR REGIONAL OFFICE USE ONLY			
17. DATE RECEIVED 9/22/2021		18. DATE APPROVED December 15, 2021	
PLAN APPROVED - ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL 7/1/2021		20. SIGNATURE OF REGIONAL OFFICIAL 	
21. TYPED NAME Rory Howe		22. TITLE Director	
23. REMARKS			

Methods and Standards for Establishing Payment Rates for Nursing Facility Services

For facilities receiving both an ICF and SNF Medicaid rate on June 30, 2001, the June 30, 2001, Medicaid rate referenced above is the patient-day-weighted average of the ICF and SNF Medicaid rates effective June 30, 2001, excluding the case-mix transition add-on amount.

The subsections below reflect the details of this reimbursement plan.

2. Definition of Allowable Costs and Calculation of Per Diem Costs

Allowable costs are determined using Medicare methods. Cost is allowable only to the extent that it relates to patient care; is reasonable, ordinary, and necessary; and is not in excess of what a prudent and cost-conscious buyer would pay for the given services or item. Only these costs are considered in calculating the Medicaid nursing facility reimbursable cost per diem for purposes of this section.

For purposes of calculating the Medicare-certified hospital-based nursing facility Medicaid reimbursement rate, facility costs are divided into two components:

- The “direct care component” is the portion attributable to the salaries and benefits of registered nurses, licensed practical nurses, certified nursing assistants, rehabilitation nurses, and contracted nursing services.
- The “non-direct care component” is the portion attributable to administrative, environmental, property, and support care costs reported on the financial and statistical report.

Each nursing facility’s per diem allowable direct care and non-direct care cost shall be established.

Effective July 1, 2001, and every second year thereafter, the per diem allowable cost shall be arrived at by dividing total reported allowable costs by total inpatient days during the reporting period. For the period beginning July 1, 2021, per diem allowable costs shall be arrived at by dividing total reported allowable costs by total inpatient days during the July 1, 2019 reporting period.

Effective July 1, 2021, and thereafter, total reported allowable costs shall be adjusted for inflation, using the SNF total market basket index, from the midpoint of the cost report period to January 1, 2019.

3. Cost Normalization

The per diem allowable direct care costs are normalized by dividing a facility’s per diem direct care costs by the facility’s cost report period case-mix index. The facility cost report period case-mix index is the average of quarterly facility-wide average case-mix indices, carried to four decimal places.

TN No.	<u>IA-21-0014</u>
Supersedes TN #	<u>IA-19-011</u>

Effective	<u>7/1/2021</u>
Approved	<u>12/15/2021</u>

Methods and Standards for Establishing Payment Rates for Nursing Facility Services

The quarters used in this average are the quarters that most closely coincide with the financial and statistical reporting period. For example, a 01/01/2001-12/31/2001 financial reporting period would use the facility-wide average case-mix indices for quarters ending 03/31/01, 06/30/01, 09/30/01, and 12/31/01.

4. Calculation of Patient-Day-Weighted Medians

A patient-day-weighted median is established for each of the Medicare-certified hospital-based nursing facility rate components.

The per diem normalized direct care cost for each facility is arrayed from low to high to determine the direct care component patient-day-weighted median cost based on the number of patient days provided by facilities.

The per diem non-direct care cost for each facility is also arrayed from low to high to determine the non-direct care component patient-day-weighted median cost based on the number of patient days provided by facilities.

For the fiscal period beginning July 1, 2001, and ending June 30, 2003, the direct care and non-direct care patient-day-weighted medians shall be calculated using the latest Medicare cost report with a fiscal year end of December 31, 2000, or earlier, inflated from the midpoint of the cost report period to July 1, 2001.

Effective July 1, 2003, and each second year thereafter, the patient-day-weighted medians used in rate setting shall be recalculated, using the latest completed Medicare cost report with a fiscal year end of the preceding December 31 or earlier. Effective July 1, 2021, and thereafter, total reported allowable costs shall be adjusted for inflation, using the SNF total market basket index, from the midpoint of the cost report period to January 1, 2019.

5. Excess Payment Allowance Calculation

The Medicare-certified hospital-based nursing facility excess payment allowance is calculated as follows:

- a. For the direct care component, subject to the limit provided below, the excess payment allowance is equal to zero (0) percent times the difference of the following (if greater than zero):
 - The direct care patient-day-weighted median times 95 percent times the provider’s Medicaid average case-mix index, minus
 - A provider’s normalized allowable per patient day direct care costs times the provider’s Medicaid average case-mix index.

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However, for purposes of calculating the per diem cost for administrative, environmental, and property expenses, total patient days are the greater of the actual inpatient days or 85 percent of the facility’s license capacity.

Effective July 1, 2021, and thereafter, total reported allowable costs shall be adjusted for inflation, using the SNF total market basket index, from the midpoint of the cost report period to January 1, 2019.

b. Cost Normalization

The per diem allowable direct care costs are normalized by dividing a facility’s per diem direct care costs by the facility’s cost report period case-mix index. The facility cost report period case-mix index is the average of quarterly facility-wide average case-mix indices, carried to four decimal places.

The quarters used in this average are the quarters that most closely coincide with the financial and statistical reporting period. For example, a 01/01/2001-12/31/2001 financial reporting period would use the facility-wide average case-mix indices for quarters ending 03/31/01, 06/30/01, 09/30/01, and 12/31/01.

c. Calculation of Patient-Day-Weighted Medians

A patient-day-weighted median is established for each of the non-state-owned nursing facility rate components.

The per diem normalized direct care cost for each non-state-owned facility is arrayed from low to high to determine the direct care component patient-day-weighted median cost based on the number of patient days provided by facilities.

The per diem non-direct care cost for each facility is also arrayed from low to high to determine the non-direct care component patient-day-weighted median cost based on the number of patient days provided by facilities.

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Methods and Standards for Establishing Payment Rates for Nursing Facility Services

For the fiscal period beginning July 1, 2001, and ending June 30, 2003, the non-state-owned direct care and non-direct care patient-day-weighted medians shall be calculated using the latest financial and statistical report with a fiscal year end of December 31, 2000, or earlier, inflated from the midpoint of the cost report period to July 1, 2001.

Effective July 1, 2003, and each second year thereafter, the patient-day-weighted medians used in rate setting shall be recalculated using the latest completed financial and statistical report with a fiscal year end of the preceding December 31 or earlier. Effective July 1, 2021, and thereafter, total reported allowable costs shall be adjusted for inflation, using the SNF total market basket index, from the midpoint of the cost report period to January 1, 2019.

d. Excess Payment Allowance Calculation

Two classes of non-state-operated providers are recognized for computing the excess payment allowance calculation.

- Facilities that are located in a metropolitan statistical area (MSA) as defined by CMS.
- Facilities that are not located in an MSA.

For non-state-operated facilities not located in an MSA, the excess payment allowance is calculated as follows:

- (1) For the direct care component, subject to the limit provided below, the excess payment allowance is equal to zero (0) percent times the difference of the following (if greater than zero):
 - The direct care non-state-operated patient-day-weighted median times 95 percent times the provider’s Medicaid average case-mix index, minus
 - A provider’s normalized allowable per patient day direct care costs times the provider’s Medicaid average case-mix index.

In no case shall the excess payment allowance exceed ten percent times the non-state-operated direct care patient-day-weighted median.

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